NEW YORK CITY DEPARTMENT OF CORRECTION
CORRECTION YOUTH EXPLORER PROGRAM POST#0072
NYCD Headquarters
Bulova Corporate Center Suite 320
75-20 Astoria Boulevard
East Elmhurst NY 11370
718-546-3100

The mission of the NYC Department of Correction Youth Explorer Post is to foster leadership and self-development within it's' participants. The goal of the program is to provide an understanding and knowledge of the Department of Correction and other law enforcement agencies. The Explorers will become leaders in their communities and comprehension for law and law enforcement.

Eligibility Requirements:

- 14-17 years old
- Enrolled in a high school
- Not enrolled in another Explorer post
- A good student with a minimum grade point average of 2.0 or a 70% average and have regular attendance.
- Be willing to actively participate in community service activities.

The application packet contains the following documents: A Learning for Life Application, P.A.L. Application and a multimedia consent form. By becoming a DOC Youth Explorer, you will also become a member of the Police Athletic League and will have access to the services provided by Brownsville Beacon and P.A.L.

Upon submission of the application, please provide the following documents:

1. Copy of your last report card
2. Teacher or guidance counselor recommendation
3. Copy of your school ID

If you have any questions about the application or the DOC Youth Explorers program, please contact youthexplorers@doc.nyc.gov.

Explorer Club

For Sixth-, Seventh-, and Eighth-Graders

The Explorer Club Learning for Life career education program is for young men and women who are in the sixth, seventh, and eighth grades.

The Explorer Club's purpose is to provide experiences to help young people learn about different careers.

Real-World Career Experiences

Exploring®

The Exploring Learning for Life career education program is for young men and women who are at least 14 (and have completed the eighth grade) or 15 years of age but not yet 21 years old.

Exploring's purpose is to provide experiences to help young people mature and become responsible and caring adults. Explorers are ready to explore the meaning of interdependence in their personal relationships.

YOUTH APPLICATION

Exploring is based on a unique and dynamic relationship between youth and the organizations in their communities. Local community organizations initiate a specific Explorer post or club by matching their people and program resources to the interests of young people in the community. The result is a program of activities that helps youth pursue their special interests, grow, and develop.

Explorer posts/clubs can specialize in a variety of career skills. Exploring programs are based upon five areas of emphasis: career opportunities, life skills, citizenship, character education, and leadership experience.

LEARNING FOR LIFE®
PreK-12 Programs Career Exploring

524-009
2014 Printing

Tips for completing the Application for Exploring Youth Participant:

- Print—do not use cursive.
- Use black or dark blue ink.
- Press firmly when printing.
- Print one letter only in each box.
- Use uppercase letters and stay within the blue boxes for legibility.
- Fill in circles; do not use check marks.
- Make sure you have all needed signatures on application.
- Don't alter the application—it could affect the quality of the scan.

Mailing address example:

7	0	3		F	I	R	S	T		S	T	

Participant Chart

Term per month	Youth/adult participant fee
1	2.00
2	4.00
3	6.00
4	8.00
5	10.00
6	12.00
7	14.00
8	16.00
9	18.00
10	20.00
11	22.00
12	24.00
13	26.00
14	28.00
15	30.00
16	32.00
17	34.00
18	36.00

Cut along dotted line.

TEMPORARY PARTICIPANT CERTIFICATE
(Good for 60 days)
This certifies that

_____

is a member of _____

_____
Post or club leader signature

_____
Date

Explorer Club Exploring

USE BLACK OR DARK BLUE INK ONLY.

- Print—do not use cursive.
- Print one letter or number only in each box.
- Use uppercase letters and stay within the blue boxes for legibility.

- Fill in radio buttons completely.

○ Exploring Post ○ Explorer Club Number:

(Print one letter in each space—press hard, you are making a copy.)

First name: KATHLEEN | Middle name: JANE | Last name: SMITH | Suffix:

Country: US | Mailing address: 1234 ANY STREET | City: ANYTOWN | NY | 12345

Phone: 555-123-4567 | Date of birth (mm/dd/yyyy): 01/01/1998 | Grade: 10

Ethnic background: ○ Black/African American ● Native American ○ Alaska Native ○ Asian ○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

Gender: ○ Male ● Female

School: OAK TREE HIGH SCHOOL

Email address (Post youth participant only): KATHYJS@MYMAIL.COM

Parent/guardian information

Select relationship: ○ Parent ○ Guardian ● Grandparent ○ Other (specify)

First name (No initials or nicknames): DEBORAH | Middle name: SUE | Last name: SMITH | Suffix:

Country: US | Mailing address: 1234 ANY STREET | City: ANYTOWN | State: NY | Zip code: 12345

Home phone: 555-123-4567 | Date of birth (mm/dd/yyyy): 01/01/1972 | Occupation: VP OPERATION | Employer: RGK INTL | Gender: ○ M ● F

Business phone: 555-765-4321 x | Ext. | Previous Exploring experience: FIRE EXPLORER | Cell phone: 555-253-6118

Parent/guardian email address: DEBORAH.SMITH@

- Make sure you have all needed signatures on application.

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Bill Taylor
Signature of post or club leader

05 / 13 / 2013
Date

Deborah Sue Smith
Signature of parent/guardian

Kathy Smith
Signature of Explorer

Participation fee $ ___ . ___ Paid: ☐ Cash ☐ Check No. _____ ☐ Credit card

524-009

Retain on file for three years.

YOUTH PARTICIPANT

○ Exploring Post ○ Explorer Club Number:

If applicant has an unexpired participant certificate, participation may be accomplished at no charge by transferring the registration. Mark and attach a copy of the certificate.

○ Transfer application Transfer from council no.:

○ Exploring Post ○ Explorer Club Number:

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)** | Middle name | Last name | Suffix

Country | Mailing address | City | State | Zip code

U S

Phone - - | Date of birth (mm/dd/yyyy) / / | Grade

Ethnic background:

○ Black/African American ○ Native American ○ Alaska Native ○ Asian

○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

School

Gender: ○ Male ○ Female

Email address (Post youth participant only) @

Parent/guardian information

Select relationship: ○ Parent ○ Guardian ○ Grandparent ○ Other (specify)

First name **(No initials or nicknames)** | Middle name | Last name | Suffix

Country | Mailing address | City | State | Zip code

U S

Home phone - - | Date of birth (mm/dd/yyyy) / / | Occupation | Employer | Gender: ○ M ○ F

Business phone - - X Ext. | Previous Exploring experience | Cell phone -

Parent/guardian email address @

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of post or club leader | Date / /

Signature of parent/guardian

Signature of Explorer

Participation fee $. Paid: ☐ Cash ☐ Check No. _____ ☐ Credit card

POST OR CLUB COPY

Retain on file for three years. 524-009

Learning for Life and Exploring Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Learning for Life and Exploring Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, Learning for Life recommends that everyone who participates in a Learning for Life or Exploring event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this form will help ensure you meet the minimum standards for participation in various activities. Note that adult leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed at least annually by participants in all Learning for Life and Exploring events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed heath-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the post/club/group more than 30 minutes away from an emergency vehicle or an accessible roadway, or to remote areas.

Risk Factors

Based on the vast experience of the medical community, Learning for Life has identified that the following risk factors may define your participation in various outdoor activities.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit the Safety First Guidelines on www.learningforlife.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. An adult leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but Learning for Life does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____

DOB: _____

Outing participants:
Post/club/group No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Learning for Life activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Learning for Life, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with Learning for Life volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Learning for Life activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities

☐ Without restrictions

☐ With special considerations or restrictions (list) _____

_____

Talent Release Agreement

I hereby assign and grant to Learning for Life the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by Learning for Life, and I hereby release Learning for Life from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of Learning for Life, and I specifically waive any right to any compensation I may have for any of the foregoing.

☐ Yes ☐ No

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS

You must designate at least one adult. Please include a telephone number.

1. Name _____ Telephone _____

2. Name _____ Telephone _____

3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____

2. Name _____

3. Name _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Participant's name: _____ Date: _____

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B: General Information/Health History

Full name: _____

DOB: _____

Outing participants:
Post/club/group No.: _____
or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Post/club/group leader: _____ Mobile phone: _____

Council Name/No.: _____ Post/club/group No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date:**
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes ☐ No ☐**
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B: General Information/Health History

Full name: _____

DOB: _____

Outing participants:
Post/club/group No.: _____
or staff position: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:** _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**

Immunization

The following immunizations are recommended by Learning for Life. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

Please list any additional information about your medical history:

_____

_____

_____

_____

DO NOT WRITE IN THIS BOX
Review for program or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

Outing participants:
Post/club/group No.: _____
or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Learning for Life or Exploring experience.

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

Height (inches): _____ **Weight (lbs.):** _____ **BMI:** _____ **Blood Pressure:** _____/_____ **Pulse:** _____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Learning for Life and/or Exploring experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Does not have uncontrolled heart disease, asthma, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's Signature: _____ **Date:** _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned program or special activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

The Police Athletic League is an equal opportunity employer and program

PAL TEEN CENTER 2016-2017

PAL BROWNSVILLE BEACON
985 Rockaway Avenue, Brooklyn, NY 11212
Tel. (718) 485-2719 | www.palnyc.org

Confidentiality: Any information requested is for our records and for the funding our organization receives. The answers you provide will be kept completely confidential. Your cooperation in providing this information is both appreciated and necessary.

Confidencialidad: *Cualquier información solicitada es para nuestros expedientes y para los que otorgan financiamiento a nuestra organización. Las respuestas que usted proporciona serán mantenidas totalmente confidenciales. Su cooperación en el abastecimiento de esta información es apreciada y necesaria.*

⇩ PARTICIPANT's Information / *Información del* PARTICIPANTE

First Name/*Primer Nombre*: M.I.: Last Name/*Apellido*:

Address/*Dirección*:

City, State/*Ciudad, Estado*: Zip Code/*Código Postal*: Address Type/*Tipo de Dirección*: ☐ Home/*Casa* ☐

Phone Number/*Número de Télefono*: ( ) - Ext. Phone Type/*Tipo de Número de Télefono*: ☐ Home/*Casa* ☐ Work/*Trabajo* ☐ Cell/*Celular* ☐

( ) - Ext. ☐ Home/*Casa* ☐ Work/*Trabajo* ☐ Cell/*Celular* ☐

E-Mail (Please print/*Letra del molde por favor*): Date of Birth/*Fecha de Nacimiento*: / /

Gender/*Género*: ☐ Male/*Masculino* ☐ Female/*Femenino*

Ethnicity/*Pertenencia Étnica*: ☐ African American/*Afro Ameri* ☐ Asian/*Asiatico* ☐ Hispanic/*Latino* ☐ White/*Blanco* ☐ Other/*Otro*

School/*Escuela*: Grade/Grado:

Household Type/*Tipo de la Casa*: ☐ Married/*Casado* ☐ Divorced/*Divorciado* ☐ Partnered/*Parejo* ☐ Separated/*Separado* ☐ Single/*Soltero* ☐ Other/*Otro*

Family Size/*Tamaño de la Familia*: Number of adults (18+) in household/*Adultos (18+) en el hogar*

Number of children in household/*Niños en el hogar*

⇩ PARENT/GUARDIAN Information / *Información del* PADRE/GUARDA

First Name/*Primer Nombre*: Last Name/*Apellido*:

Address/*Dirección*:

City, State/*Ciudad, Estado*: Zip Code/*Código Postal*: Address Type/*Tipo de Dirección*: ☐ Home/*Casa* ☐

Phone Number/*Número de Télefono*: ( ) - Ext. Phone Type/*Tipo de Número de Télefono*: ☐ Home/*Casa* ☐ Work/*Trabajo* ☐ Cell/*Celular* ☐

( ) - Ext. ☐ Home/*Casa* ☐ Work/*Trabajo* ☐ Cell/*Celular* ☐

Continue on the next page ⇨

FOR INTERNAL USE ONLY

Membership: ☐ Returning ☐ New **Date Received:**

NOTES:

PALtrax ID: **Entered by:**

⇩ Medical Information (Please print) / *Información Médica (Letra del molde por favor)*

Medical Problems or Allergies/*Los Problemas Médicos y Alergias*:

☐ I have disclosed all medical conditions that would prohibit my child, or myself if I am over the age of 18, from participating in the Evening Teen Program activities.

Medication Policy

It is the responsibility of the participant to ensure that required medication is taken when needed. PAL is not responsible for dispensing any medication or reminding any participant to take his/her medication.

Póliza de Medicamentos

Es la responsabilidad del participante de asegurarse de que la medicina requerida sea tomada cuando necesario. PAL no es responsable de dispensar ninguna medicina o de recordar a ningún participante de tomar su medicina.

Emergency Medical Release

If emergency medical care is required and my Emergency Contact cannot be reached, I give my consent to PAL to obtain the necessary medical care. I agree to pay all of the costs associated with the emergency medical care that I receive. I understand that every effort will be made to reach my Emergency Contact before and after medical care is provided.

Absuelto de Tratamiento de Emergencias Médica

Si la atención médica de emergencia es necesaria, y mi contacto de emergencia no pueda ser localizado, doy mi consentimiento para PAL para obtener la atención médica necesaria. Estoy de acuerdo en pagar todos los costos relacionados con la atención médica de emergencia que reciben. Entiendo que cada esfuerzo será hecho para llegar a mi contacto de emergencia antes y después de la atención médica se proporciona.

Consent

I understand that this consent will be in effect as of the date of my signing this form and will continue as long as I am enrolled in the PAL program.

Consentimiento

Entiendo que este consentimiento tendrá validez a partir de la fecha en que yo firme el presente formulario y se mantendrá mientras que yo esté inscrito en el programa de PAL.

Parent's/Guardian's Signature/*Firma del Padre/Guarda*:

Date/*Fecha*: ☐☐ / ☐☐ / ☐☐☐☐

Participant's Signature/*Firma del Participante*:

Date/*Fecha*: ☐☐ / ☐☐ / ☐☐☐☐

⇩ Behavioral Rules and Regulations / *Reglas y Regulaciones de Conducta*

PAL Mission Statement

The Police Athletic League, together with the NYPD and the law enforcement community, supports and inspires New York City youth to realize their full individual potential as productive members of society.

Declaración de Misión de PAL

La Liga Atletica Policiaca en conjunto con el Departamento de La Policia de la Ciudad Nueva York (NYPD) y la comunidad que enforza la ley apoya, e inspira a los jovenes de la Ciudad de Nueva York a realisar su maximo potencial individual como productivos miembros de la sociedad.

For this reason and for the safe and secure management of the center, participants and staff are expected to:

- show respect for others, themselves, and PAL property.
- listen to one another and remain quiet while others are speaking.
- use respectful language.
- keep their hands to themselves.
- remain in the building during program hours.
- cooperate with PAL staff by following directions.
- participate in activities and events.
- remain with their groups at all times.
- take off hats and "durags" while in the center.
- leave all cell phones, bicycles, skateboards, iPods and/or other mp3 players, video games, and toys at home.
- clean up after themselves.
- walk quietly in the halls, bathrooms, during fire drills, dismissal, etc.

Por esta razón y para la gestión segura del centro, los participantes y el personal se espera que:

- *mostrar respeto por los demás, ellos mismos, y la propiedad PAL.*
- *escucharnos unos a otros y permanecer en silencio mientras que otros están hablando.*
- *usar un lenguaje respetuoso.*
- *mantener las manos a sí mismos.*
- *permanecer en el edificio durante las horas del programa.*
- *al seguir direcciones y cooperar con el personal de PAL.*
- *participar en actividades y eventos.*
- *permanecer con sus grupos en todo momento.*
- *quitar los sombreros y "durags", mientras estén en el centro.*
- *deje todos los teléfonos celulares, bicicletas, patinetas, los iPods y / u otros reproductores de mp3, los videojuegos y los juguetes en casa.*
- *limpiar después de ellos mismos.*
- *pie en silencio en los pasillos, cuartos de baño, durante los simulacros de incendio, el despido, etc.*

Consent

I have read the policies and regulations detailed on this page and agree to abide by them as stated.

I hereby release and discharge PAL and any of its staff members from liability in the event of any injury or accident.

Consentimiento

Yo he leido las pólizas y regulaciones detalladas en esta pagina y estoy en acuerdo a seguirlas segun estan indicadas.

Yo libero y descargo a PAL y sus empleados de cargos de responsabilidad en el evento de cualquier lesión o accidente.

Photo/Video Consent

Please check one: ☐ I give permission... ☐ I do not give permission...

...to be photographed or otherwise recorded and publicized when involved in a PAL authorized event.

Consentimiento de Fotos/Videos

Por favor escoja uno: ☐ *Doy el permiso...* ☐ *No doy mi permiso...*

...para ser fotografiado o por otra parte registrado y hecho público cuando implicado en un acontecimiento oficial.

Participant's Signature/*Firma del Participante*:

Date/*Fecha*: ☐☐ / ☐☐ / ☐☐☐☐

NEW YORK CITY DEPARTMENT OF CORRECTION
Joseph Ponte, Commissioner
Nadene M. Pinnock, Deputy Commissioner
Claudette Wynter, Assistant Commissioner
Human Resources
75-20 Astoria Boulevard, Suite 320
East Elmhurst, New York. 11370
Tel 718 • 546 • 3100
Fax 718 • 278 • 6084

Consent to Photograph, Film or Videotape a Visitor for Non-Profit Use

Name of Visitor: _____

I hereby consent to the participation in interviews, the use of quotes, the taking of photographs, movies or videotapes.

I also grant the New York City Department of Correction the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet and all forms of social media. I also hereby release the New York City Department of Correction and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

If under 18 years of age:
I am a parent or guardian of the above minor, and I hereby agree to the above terms on his/her behalf.
Name of Parent/Guardian: _____
Signature: _____ Date: _____
Address: _____

If over 18 years of age:
Name: _____ Date of Birth: _____
Signature: _____ Date: _____
Address: _____